

<b>Case Number:</b>	CM15-0140565		
<b>Date Assigned:</b>	08/05/2015	<b>Date of Injury:</b>	04/06/2012
<b>Decision Date:</b>	09/03/2015	<b>UR Denial Date:</b>	07/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/20/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Emergency Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 38-year-old male, who sustained an industrial injury on April 6, 2012. Treatment to date has included transforaminal epidural steroid injection, TENS unit, home exercise program, and medications. Currently, the injured worker complains of constant completely back pain with burning and stiffness. He describes his low back and groin pain as constant numbness and tingling, which is worsened with cold weather and activity. The pain radiates to the bilateral lower extremities with numbness, tingling and stiffness. He wears a low back support. He reports some trouble controlling his bowel movements due to his pain. His neck and upper back pain are constant, burning sensation with associated numbness. His neck and upper back pain are made worse with cold weather and activity and he reports occasional radiation of pain to the bilateral upper extremities. He has associated cramping, numbness and tingling to the bilateral fingers and frequent throbbing headaches. He reports constant throbbing pins and needles sensation to the chest, which is made worse with activity. His chest pain is reproducible with palpation. He reports left wrist pain, which is described as intermittent, stabbing, cramping with dullness and tingling. He reports that his medications, Lidoderm cream, home exercise program and TENS unit are helpful with the pain. The diagnoses associated with the request include cervical sprain-strain, lumbosacral sprain-strain, and pain in left wrist, contusion of chest, myofascial pain and chronic pain syndrome. The treatment plan includes physical medication and rehabilitation consultation for functional restoration program, continued Naproxen, Omeprazole, Lidopro cream, continued home exercise program and TENS unit, cognitive behavioral therapy, additional physical therapy and follow-up evaluation.

## **IMR ISSUES, DECISIONS AND RATIONALES**

The Final Determination was based on decisions for the disputed items/services set forth below:

**PM& R C/S regarding functional restoration program:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs(functional restoration programs) Page(s): 30-32.

**Decision rationale:** As per MTUS Chronic pain guidelines, certain criteria should be met before recommendation to a program. It requires: 1) A functional baseline testing to measure baseline improvement. Fails criteria. 2) Failure of prior chronic pain treatment. Meets criteria. 3) Loss of function due to pain. Meets criteria. 4) Not a candidate for surgery. Meets criteria. 5) Motivation to change. Fails criteria. Pt appears depressed and has no plans of returning to prior work. There is no assessment of this criteria noted. 6) Negative predictors for success has been addressed. Fails criteria. No assessment of this criteria was documented. There is no proper assessment of negative predictors noted. The request for service is also open-ended and does not have a baseline assessment of function noted or an initial assessment before a full FRP is indicated. The request is also incomplete with total number of sessions not included in request. Functional Restoration Program is not medically necessary.